FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043398

Facility Name: BURNHAM HEALTHCARE

Address: 14500 S. MANISTEE (Number) BURNHAM (City) 60633 (Zip Code)

County: COOK

Telephone Number: (708) 862-1260 **Fax #** (708) 862-1263

IDPA ID Number: 36-4205217

Date of Initial License for Current Owners: 03/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,698	1
2		Skilled Pediatric (SNF/PED)			2
3	206	Intermediate (ICF)	206	75,396	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	309	TOTALS	309	113,094	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	39,324	801	9,160	49,285	8
9	SNF/PED					9
10	ICF	61,370	423	145	61,938	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	100,694	1,224	9,305	111,223	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.35%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 9,091

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	303,551	39,780	15,555	358,886		358,886		358,886			1
2	Food Purchase		419,251		419,251	(21,777)	397,474	(1,447)	396,027			2
3	Housekeeping	286,910	35,699		322,609		322,609		322,609			3
4	Laundry	117,326	29,755	11,976	159,057		159,057	308	159,365			4
5	Heat and Other Utilities			178,394	178,394		178,394	767	179,161			5
6	Maintenance	264,502	70,691	70,029	405,222		405,222	5,296	410,518			6
7	Other (specify):*			28,460	28,460		28,460	136	28,596			7
8	TOTAL General Services	972,289	595,176	304,414	1,871,879	(21,777)	1,850,102	5,060	1,855,162			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	3,139,688	145,417	20,618	3,305,723		3,305,723		3,305,723			10
10a	Therapy	101,212	893	34,923	137,028		137,028		137,028			10a
11	Activities	139,238	56,575	4,068	199,881		199,881		199,881			11
12	Social Services	197,760		19,780	217,540		217,540		217,540			12
13	Nurse Aide Training											13
14	Program Transportation			125	125		125		125			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,577,898	202,885	85,014	3,865,797		3,865,797		3,865,797			16
	C. General Administration											
17	Administrative	130,714		378,000	508,714		508,714	(262,704)	246,010			17
18	Directors Fees											18
19	Professional Services			68,771	68,771		68,771	18,979	87,750			19
20	Dues, Fees, Subscriptions & Promotions			36,645	36,645		36,645	(7,281)	29,364			20
21	Clerical & General Office Expenses	226,578	29,241	113,535	369,354		369,354	(59,263)	310,091			21
22	Employee Benefits & Payroll Taxes			827,085	827,085	21,777	848,862		848,862			22
23	Inservice Training & Education							124	124			23
24	Travel and Seminar			6,287	6,287		6,287		6,287			24
25	Other Admin. Staff Transportation			3,452	3,452		3,452	1,248	4,700			25
26	Insurance-Prop.Liab.Malpractice			146,120	146,120		146,120	19,093	165,213			26
27	Other (specify):*			384,984	384,984		384,984	(375,388)	9,596			27
28	TOTAL General Administration	357,292	29,241	1,964,879	2,351,412	21,777	2,373,189	(665,192)	1,707,997			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,907,479	827,302	2,354,307	8,089,088		8,089,088	(660,132)	7,428,956			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: BURNHAM HEALTHCARE #0043398 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	15,555	
	REPAIRS & MAINTENANCE		0	
			0	15,555
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		11,976	
			0	11,976
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		70,547	
	ELECTRICITY		69,251	
	WATER		38,596	
	CABLE TV - LOBBY		0	
			0	178,394
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,498	
	PAINTING & DECORATING		3,092	
	BUILDING REPAIRS		10,970	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		21,796	
	ELEVATOR MAINTENANCE & REPAIR		17,345	
	OUTSIDE LABOR		417	
	EXTERMINATING SERVICE		5,349	
	FIRE SERVICE		6,562	
			0	
			0	
			0	70,029
7	**OTHER**			
	SCAVENGER		17,456	
	SECURITY SERVICE		11,004	28,460
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,500	5,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		85	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	42	
	PHARMACY CONSULTANT	XVIII B 39-2	10,791	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	6,000	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,700	
			0	20,618
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		1,676	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	28,441	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	4,806	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	34,923
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,068	
			0	4,068
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	189	
	SOCIAL WORKER	XVIII B 45-2	19,591	
			0	19,780
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BURNHAM HEALTHCARE **#0043398** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		125	125
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	378,000	378,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	21,175	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	47,596	
			0	68,771
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,936	
	EMPLOYEE WANT ADS	XIX F	5,828	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	11,307	
	LICENSES & PERMITS	XIX F	10,438	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,592	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	44	36,645
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		3,669	
	EQUIPMENT REPAIR & MAINTENANCE		4,885	
	OUTSIDE CLERICAL SERVICES		72,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	2,732	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		23,676	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		6,573	113,535

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	370,567	
	UNEMPLOYMENT COMPENSATION	XIX D	85,461	
	WORKERS COMPENSATION INSURANCI	XIX D	115,194	
	HOSPITALIZATION INSURANCE	XIX D	212,453	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,558	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	40,852	
	CHICAGO HEAD TAX	XIX D	0	827,085
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	6,287	
	TRAVEL	XIX G	0	
			0	
			0	6,287
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,452	3,452
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		146,120	146,120
27	**OTHER**			
	BAD DEBTS	VI 24	384,984	
				384,984

GRAND TOTAL COLUMN 3 OTHER 2,354,307

Facility Name & ID Number BURNHAM HEALTHCARE #0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			162,679	162,679		162,679	357,840	520,519			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							846,987	846,987			32
33	Real Estate Taxes			33,920	33,920		33,920	731,508	765,428			33
34	Rent-Facility & Grounds			1,821,500	1,821,500		1,821,500	(1,164,540)	656,960			34
35	Rent-Equipment & Vehicles			42,996	42,996		42,996	8,947	51,943			35
36	Other (specify):* amort software/ime rent			31,419	31,419		31,419	(24,102)	7,317			36
37	TOTAL Ownership			2,092,514	2,092,514		2,092,514	756,640	2,849,154			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		248,610	174,704	423,314		423,314		423,314			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,642	169,642		169,642		169,642			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		248,610	344,346	592,956		592,956		592,956			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,907,479	1,075,912	4,791,167	10,774,558		10,774,558	96,508	10,871,066			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

BURNHAM HEALTHCARE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	419,251
LESS SALES TAX	(1,447)
NET FOOD	417,804
TOTAL PATIENT CENSUS	111,223
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	333669
ADD # EMPLOYEE MEALS/DAY	50
TIME # DAYS	366
TOTAL EMPLOYEE MEALS	18300

PATIENT MEALS	333669
ADD EMPLOYEE MEALS	18300
TOTAL MEALS/YEAR	351969
NET FOOD	417804
DIVIDE TOTAL MEALS/YEAR	351969
COST PER MEAL	1.19
TIME EMPLOYEE MEALS	18300
EMPLOYEE MEAL RECLASSIFICATION	21777

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,579	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,447)	2		13
14	Non-Care Related Interest	(8,574)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(2,732)	21		18
19	Entertainment		20		19
20	Contributions	(6,092)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(384,984)	27		24
25	Fund Raising, Advertising and Promotional	(2,936)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(74,786)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (475,972)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	572,480		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 572,480		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 96,508		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BURNHAM HEALTHCARE

ID# 0043398

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -256	6	1
2	STAFF DEVELOPMENT	(6,573)	21	2
3	MARKETING SALARY	(31,288)	21	3
4	BANK CHARGES	(3,669)	21	4
5	MANAGEMENT FEES - P. ESFORMES	(33,000)	17	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(74,786)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,447)	0	0	0	0	0	0	0	0	0	0	(1,447)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	308	0	0	0	0	0	0	0	0	308	4
5	Heat and Other Utilities	0	0	0	767	0	0	0	0	0	0	0	767	5
6	Maintenance	(256)	0	3,611	1,941	0	0	0	0	0	0	0	5,296	6
7	Other (specify):*	0	0	54	82	0	0	0	0	0	0	0	136	7
8	**TOTAL General Services**	(1,703)	0	3,973	2,790	0	0	0	0	0	0	0	5,060	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(33,000)	(241,652)	11,948	0	0	0	0	0	0	0	0	(262,704)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	281	11,576	122	7,000	0	0	0	0	0	0	18,979	19
20	Fees, Subscriptions & Promotions	(9,028)	0	1,747	0	0	0	0	0	0	0	0	(7,281)	20
21	Clerical & General Office Expenses	(44,262)	13,617	(28,957)	339	0	0	0	0	0	0	0	(59,263)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	124	0	0	0	0	0	0	0	0	124	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	392	856	0	0	0	0	0	0	0	0	1,248	25
26	Insurance-Prop.Liab.Malpractice	0	0	571	403	18,119	0	0	0	0	0	0	19,093	26
27	Other (specify):*	(384,984)	1,877	7,719	0	0	0	0	0	0	0	0	(375,388)	27
28	**TOTAL General Administration**	(471,274)	(225,485)	5,584	864	25,119	0	0	0	0	0	0	(665,192)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(472,977)	(225,485)	9,557	3,654	25,119	0	0	0	0	0	0	(660,132)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	5,579	0	456	2,350	349,455	0	0	0	0	0	0	357,840	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,574)	0	0	3,058	852,503	0	0	0	0	0	0	846,987	32
33	Real Estate Taxes	0	0	0	3,293	728,215	0	0	0	0	0	0	731,508	33
34	Rent-Facility & Grounds	0	0	0	0	(1,164,540)	0	0	0	0	0	0	(1,164,540)	34
35	Rent-Equipment & Vehicles	0	1,135	7,580	232	0	0	0	0	0	0	0	8,947	35
36	Other (specify):*	0	0	0	(24,102)	0	0	0	0	0	0	0	(24,102)	36
37	TOTAL Ownership	(2,995)	1,135	8,036	(15,169)	765,633	0	0	0	0	0	0	756,640	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(475,972)	(224,350)	17,593	(11,515)	790,752	0	0	0	0	0	0	96,508	45

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				EKS MNGT	LINCOLNWOOD	MANAGEMENT
				EMI ENTERPRISE	LINCOLNWOOD	CONSULTING
				IME REALTY CORP	LINCOLNWOOD	HOME OFFICE
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 265,000	EMI ENTERPRISE		$	$ (265,000)	1
2	V								2
3	V	17	OFFICER'S SALARY				23,348	23,348	3
4	V	19	ACCOUNTING FEES				281	281	4
5	V	21	OFFICE EXPENSE				13,617	13,617	5
6	V	25	TRANSPORTATION				392	392	6
7	V	26	INSURANCE						7
8	V	27	EMPLOYEE BENEFITS				1,877	1,877	8
9	V	35	AUTO LEASE				1,135	1,135	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 265,000			$ 40,650	$ * (224,350)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 72,000	EKS MANAGEMENT		$	$ (72,000)	15
16	V								16
17	V	4	HOUSEKEEPING SALARIES				308	308	17
18	V	6	PAINTING SALARIES				3,611	3,611	18
19	V	7	SCAVENGER				54	54	19
20	V	17	C F O SALARY				11,948	11,948	20
21	V	19	PROFESSIONAL FEES				11,576	11,576	21
22	V	20	WANT ADS				1,747	1,747	22
23	V	21	OFFICE EXPENSE				43,043	43,043	23
24	V	23	SEMINARS				124	124	24
25	V	25	TRANSPORTATION				856	856	25
26	V	26	INSURANCE				571	571	26
27	V	27	EMPLOYEE BENEFITS				7,719	7,719	27
28	V	30	DEPRECIATION				456	456	28
29	V	35	EQUIPMENT RENT				7,580	7,580	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,000			$ 89,593	$ * 17,593	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 24,102	IME REALTY CORP		$	$ (24,102)	15
16	V								16
17	V	5	UTILITIES				767	767	17
18	V	6	REPAIRS/ MAINT				1,941	1,941	18
19	V	7	ALARM SERVICE				82	82	19
20	V	19	PROFEESIONAL FEES				122	122	20
21	V	21	OFFICE EXPENSE				339	339	21
22	V	26	INSURANCE				403	403	22
23	V	30	DEPRECIATION				2,350	2,350	23
24	V	32	INTEREST				3,058	3,058	24
25	V	33	R/E TAX				3,293	3,293	25
26	V	35	STORAGE FEES				232	232	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 24,102			$ 12,587	$ * (11,515)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 1,164,540	BURNHAM HEALTH CARE REALTY		$	$ (1,164,540)	15
16	V	30	DEPRECIATION		BURNHAM HEALTH CARE REALTY		349,455	349,455	16
17	V	32	INTEREST		BURNHAM HEALTH CARE REALTY		852,503	852,503	17
18	V	33	REAL ESTATE TAXES		BURNHAM HEALTH CARE REALTY		728,215	728,215	18
19	V	19	PROFESSIONAL FEES		BURNHAM HEALTH CARE REALTY		7,000	7,000	19
20	V	26	INSURANCE		BURNHAM HEALTH CARE REALTY		18,119	18,119	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,164,540			$ 1,955,292	$ * 790,752	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	MEMBER	MANAGEMENT	0.38		See Attached		MNGT FEES	$ 23,348	17-8	1
2	PHILIP ESFORMES	MEMBER	MANAGEMENT	0.19		See Attached		MNGT FEES	80,000	17-8	2
3	AVRUM WEINFELD	CFO	FIN. OFFICER					SALARY	11,948	17-8	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 115,296		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N . LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD ,IL.60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER'S SALARY	PATIENT DAYS	881,303	14	$ 185,000	$ 185,000	111,223	$ 23,348	1
2	19	ACCOUNTING FEES	PATIENT DAYS	881,303	14	2,230		111,223	281	2
3	21	OFFICE EXPENSE	PATIENT DAYS	881,303	14	107,899	87,197	111,223	13,617	3
4	25	TRANSPORTATION	PATIENT DAYS	881,303	14	3,109		111,223	392	4
5	26	INSURANCE	PATIENT DAYS	881,303	14			111,223	0	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	14,871		111,223	1,877	6
7	35	AUTO LEASE	PATIENT DAYS	881,303	14	8,991		111,223	1,135	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 322,100	$ 272,197		$ 40,650	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT, INC.
Street Address: 6865 N . LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD ,IL.60712
Phone Number: (847)674-1946
Fax Number: (847)674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	881,303	14	$ 2,437	$ 2,437	111,223	$ 308	1
2	6	PAINTERS SALARIES	PATIENT DAYS	881,303	14	28,615	28,615	111,223	3,611	2
3	7	SCAVENGER	PATIENT DAYS	881,303	14	429		111,223	54	3
4	17	C F O SALARY	PATIENT DAYS	881,303	14	94,671	94,671	111,223	11,948	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	881,303	14	91,723		111,223	11,576	5
6	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	881,303	14	13,841		111,223	1,747	6
7	21	OFFICE	PATIENT DAYS	881,303	14	341,059	251,740	111,223	43,043	7
8	23	SEMINARS	PATIENT DAYS	881,303	14	984		111,223	124	8
9	25	TRANSPORTATION	PATIENT DAYS	881,303	14	6,783		111,223	856	9
10	26	INSURANCE	PATIENT DAYS	881,303	14	4,521		111,223	571	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	61,166		111,223	7,719	11
12	30	DEPRECIATION	PATIENT DAYS	881,303	14	3,617		111,223	456	12
13	35	EQUIPMENT RENT	PATIENT DAYS	881,303	14	60,061		111,223	7,580	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 709,907	$ 377,463		$ 89,593	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 675-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	312,263	14	$ 9,942	$	24,102	$ 767	1
2	6	REPAIRS / MAINT	INCOME	312,263	14	25,152		24,102	1,941	2
3	7	ALARM SERVICE	INCOME	312,263	14	1,056		24,102	82	3
4	19	PROFESSIONAL FEES	INCOME	312,263	14	1,575		24,102	122	4
5	21	OFFICE EXPENSE	INCOME	312,263	14	4,368		24,102	339	5
6	26	INSURANCE	INCOME	312,263	14	5,225		24,102	403	6
7	30	DEPRECIATION	INCOME	312,263	14	30,446		24,102	2,350	7
8	32	INTEREST	INCOME	312,263	14	39,619		24,102	3,058	8
9	33	R/E TAX	INCOME	312,263	14	42,669		24,102	3,293	9
10	35	STORAGE FEES	INCOME	312,263	14	3,011		24,102	232	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 163,063	$		$ 12,587	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BURNHAM HEALTH CARE REALTY
Street Address: 6865 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 675-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COST	1	1	$ 349,455	$	1	$ 349,455	1
2	32	INTEREST	DIRECT COST	1	1	852,503		1	852,503	2
3	33	REAL ESTATE TAXES	DIRECT COST	1	1	728,215		1	728,215	3
4	19	PROFESSIONAL FEES	DIRECT COST	1	1	7,000		1	7,000	4
5	26	INSURANCE	DIRECT COST	1	1	18,119		1	18,119	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,955,292	$		$ 1,955,292	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAMBRIDGE REALTY		X	MORTGAGE	$85,698.11	11/21/03	$ 16,088,500	$ 15,728,743	9/1/37	0.0533	$ 852,503	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$85,698.11		$ 16,088,500	$ 15,728,743			$ 852,503	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 16,088,500	$ 15,728,743			$ 852,503	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 651,239	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 689,451	2
3. Under or (over) accrual (line 2 minus line 1).		$ 38,212	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 723,923	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 762,135	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	577,666	8
	2000	586,702	9
	2001	604,899	10
	2002	651,239	11
	2003	689,451	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BURNHAM HEALTHCARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043398

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-06-313-040-000	NURSING HOME	$ 557,959.33	$ 557,959.33
2.	30-06-313-045-000	NURSING HOME	$ 2,941.39	$ 2,941.39
3.	30-06-313-051-000	NURSING HOME	$ 27,252.99	$ 27,252.99
4.	30-06-313-052-000	NURSING HOME	$ 10,970.85	$ 10,970.85
5.	30-06-313-053-000	NURSING HOME	$ 7,220.16	$ 7,220.16
6.	30-06-313-054-000	NURSING HOME	$ 83,106.19	$ 83,106.19
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 689,450.91	$ 689,450.91

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,554 B. General Construction Type: Exterior 3 STORY Frame BRICK Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1998	$ 1,500,000	1
2					2
3	TOTALS			$ 1,500,000	3

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	309		1998		$ 12,649,700	$ 324,351	39	$ 324,351	$	$ 2,193,479	4
5											5
6											6
7											7
8	IME ALLOCATION					2,258		2,258			8
	Improvement Type**										
9	ROOF			1998	74,000	1,897	39	1,897		12,359	9
10	WALLCOVERINGS			1998	39,379	1,010	39	1,010		6,573	10
11	PAINTING			1998	12,962	332	39	332		2,166	11
12	WINDOW TREATMENTS			1998	38,112	977	39	977		6,363	12
13	FENCE			1998	650	17	39	17		110	13
14	NEW WINDOWS			1998	20,445	524	39	524		3,413	14
15	PAINTERS SALARIES			1998	64,064	1,643	39	1,643		10,700	15
16	NURSE STATION			1998	23,100	592	39	592		3,856	16
17	TILING			1998	635	17	39	17		106	17
18	BUILT IN CABINETRY			1998	64,700	1,659	39	1,659		10,681	18
19	NEW COILS FOR AHV			1999	6,000	154	39	154		849	19
20	NEW BOILER			1999	20,328	521	39	521		2,872	20
21	HOT WATER TANK			1999	2,750	71	39	71		391	21
22	ROOF			1999	29,500	756	39	756		4,167	22
23	PATIO			1999	5,080	339	15	329	(10)	1,858	23
24	AWNING			1999	3,000	200	15	194	(6)	1,096	24
25	LIGHTS			1999	7,603	195	39	195		1,075	25
26	NURSE CALL STATION			1999	1,957	50	39	50		276	26
27	WINDOW TREATMENTS			1999	11,207	287	39	287		1,583	27
28	CORRIDOR BORDERS			1999	6,154	158	39	158		871	28
29	SCREENS			2000	3,543	129	27.5	129		583	29
30	AIR CONDITIONER REPLACEMENT			2001	14,540	529	27.5	529		1,857	30
31	DOOR DETECTOR			2001	1,800	65	27.5	65		229	31
32	A/C COMPRESSOR & REBUILT AIR HANDLER			2001	22,621	823	27.5	823		2,891	32
33	ROOF VENTILATORS			2001	6,898	251	27.5	251		882	33
34	BOILER			2001	63,746	2,318	27.5	2,318		8,145	34
35	WALK IN FREEZER			2001	3,750	136	27.5	136		478	35
36	DOOR			2001	2,970	108	27.5	108		379	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DRYER EXHAUST FAN	2001	$ 4,050	$ 147	27.5	$ 147	$	$ 517	37
38	DOORS	2001	1,995	72	27.5	72		253	38
39	DOORS	2001	1,723	63	27.5	63		221	39
40	FLOOR TILING & CARPETING	2001	4,497	518	5	899	381	3,596	40
41	DRAPERIES	2001	12,722	1,466	5	2,544	1,078	10,176	41
42	HOT WATER HEATER & PIPING	2002	19,857	722	27.5	722		1,814	42
43	ROOF	2002	6,150	224	27.5	224		562	43
44	ELECTRIC DOOR LOCKING SYSTEM	2002	2,326	84	27.5	84		212	44
45	DOORS	2002	10,098	367	27.5	367		922	45
46	TILING	2002	17,815	648	27.5	648		1,628	46
47	SAFETY LOCK SYSTEM	2002	5,854	213	27.5	213		535	47
48	ELEVATOR REPAIR	2002	39,650	1,442	27.5	1,442		3,623	48
49	BOILER	2002	9,550	347	27.5	347		872	49
50	ELEVATOR	2003	100,632	3,659	27.5	3,659		5,723	50
51	PATIO DOORS	2003	2,300	84	27.5	84		131	51
52	FLOORING IN ELEVATORS	2003	1,155	42	27.5	42		65	52
53	NURSES STATION	2003	6,806	247	27.5	247		387	53
54	KITCHEN CABINETS	2003	2,836	103	27.5	103		162	54
55	KITCHEN FLOORING	2003	2,673	97	27.5	97		152	55
56	PATIO TILING & LIGHTING	2003	4,688	170	27.5	170		266	56
57	COVE BASE IN ANNEX CORRIDOR	2003	824	30	27.5	30		46	57
58	HANDRAILS & BUMPER GUARDS	2003	8,565	311	27.5	311		487	58
59	LIGHTING FOR CORRIDORS	2003	1,410	51	27.5	51		80	59
60	KICKPLATES	2003	5,300	193	27.5	193		301	60
61	FREIGHT & SALES TAX ON ABOVE IMPROVEMENTS	2003	816	30	27.5	30		46	61
62	DOOR ALARM SYSTEM	2004	3,076	61	27.5	61		61	62
63	NEW FLOORING	2004	39,141	771	27.5	771		771	63
64	AIR CONDITIONING CHILLER UNIT	2004	14,876	293	27.5	293		293	64
65	TILE FLOORING	2004	4,031	79	27.5	79		79	65
66	FIRE SUPPRESSION SYSTEMS	2004	5,001	98	27.5	98		98	66
67	SHOWER, BATH & TUB ROOMS AND KITCHEN	2004	72,837	1,435	27.5	1,435		1,435	67
68	AIR CONDITIONING UNIT	2004	5,484	108	27.5	108		108	68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,619,932	$ 356,542		$ 357,985	$ 1,443	$ 2,315,910	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,614,718	$ 151,687	$ 161,472	$ 9,785		$ 955,591	71
72	Current Year Purchases	10,272	6,163	514	(5,649)		514	72
73	Fully Depreciated Assets							73
74	IME,EKS ALLOCATION		548	548				74
75	TOTALS	$ 1,624,990	$ 158,398	$ 162,534	$ 4,136		$ 956,105	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 16,744,922	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 514,940	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 520,519	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,579	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,272,015	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		309		$			3
4	Additions							4
5								5
6								6
7	TOTAL		309		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 42,996 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BURNHAM HEALTHCARE

STATE OF ILLINOIS
0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 106,458	$		$ 106,458	1
2	Licensed Speech and Language Development Therapist		hrs			2,322			2,322	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			65,924			65,924	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				231,462		231,462	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): med supplies, lab						17,148		17,148	13
14	TOTAL			$		$ 174,704	$ 248,610		$ 423,314	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,127,514	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (250,000))	1,082,684		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	193,276		6
7	Other Prepaid Expenses	4,520		7
8	Accounts Receivable (owners or related parties)	398,097		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,806,091	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	144,446		15
16	Equipment, at Historical Cost	1,664,160		16
17	Accumulated Depreciation (book methods)	(1,517,195)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 291,411	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,097,502	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 323,996	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,905		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,836		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO PRIOR OWNER	245,489		36
37	DUE TO RELATED PARTIES	827,970		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,554,196	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,554,196	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,543,306	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,097,502	$	48

*(See instructions.)

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,467,960	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,467,960	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	850,346	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(775,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 75,346	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,543,306	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,519,378	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,519,378	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	82,282	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 82,282	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,574	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,574	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PRIOR YEAR EXPENSE	14,670	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,670	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,624,904	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,871,879	31
32	Health Care	3,865,797	32
33	General Administration	2,351,412	33
	B. Capital Expense		
34	Ownership	2,092,514	34
	C. Ancillary Expense		
35	Special Cost Centers	423,314	35
36	Provider Participation Fee	169,642	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,774,558	40
41	**Income before Income Taxes (line 30 minus line 40)****	850,346	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 850,346	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,118	4,794	$ 134,929	$ 28.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,833	23,858	585,766	24.55	3
4	Licensed Practical Nurses	48,514	51,166	1,043,825	20.40	4
5	Nurse Aides & Orderlies	139,435	146,707	1,190,334	8.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,258	8,770	101,212	11.54	8
9	Activity Director					9
10	Activity Assistants	18,088	18,957	139,238	7.34	10
11	Social Service Workers	14,770	15,827	197,760	12.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	37,354	39,634	303,551	7.66	15
16	Dishwashers					16
17	Maintenance Workers	26,870	27,863	264,502	9.49	17
18	Housekeepers	36,014	38,085	286,910	7.53	18
19	Laundry	16,452	17,697	117,326	6.63	19
20	Administrator	2,092	2,307	130,714	56.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,264	3,264	31,288	9.59	23
24	Clerical	12,596	13,115	136,045	10.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,079	2,265	24,206	10.69	31
32	Other Health C: MDS	6,318	6,955	120,076	17.26	32
33	Other(specify)	9,936	10,377	99,797	9.62	33
34	TOTAL (lines 1 - 33)	407,991	431,641	$ 4,907,479 *	$ 11.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly fee	$ 15,555	1-3	35
36	Medical Director	monthly fee	5,500	9-3	36
37	Medical Records Consultant	monthly fee	42	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	10,791	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant	monthly fee	28,441	10a-3	41
42	Respiratory Therapy Consultant	monthly fee	4,806	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	85	4,068	11-3	44
45	Social Service Consultant	monthly fee	19,780	12-3	45
46	Other(specify)				46
47	Physian Consultant	monthly fee	6,000	10-3	47
48	Dental Consultant	monthly fee	3,700	10-3	48
49	TOTAL (lines 35 - 48)	85	$ 98,683		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
FRED BERKOVITS	ADMIN		$ 130,714
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 130,714

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 265,000
PHILIP ESFORMES, INC	113,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 378,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		68,771
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 68,771

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 115,194
Unemployment Compensation Insurance		85,461
FICA Taxes		370,567
Employee Health Insurance		212,453
Employee Meals		21,777
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		2,558
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		40,852
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 848,862

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,090
Advertising: Employee Recruitment	5,828
Health Care Worker Background Check	44
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	2,936
TRUST/FRANCHISE/CONTRIB/ETC	6,092
LICENSES & PERMITS	6,348
DUES & SUBSCRIPTIONS	11,307
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(6,092)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,936)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,617

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	6,287
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,287

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	2003	$ 6,962	3 YRS	$	$	$ 1,160	$ 2,321	$ 2,321	$ 1,160	$	$	$
2	PAINTING/DECORATIN	2004	3,092	3 YRS				515	1,031	1,031	515		
3													
4													
5													
6													
7													
8													
9													
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20	TOTALS		$ 10,054		$	$	$ 1,160	$ 2,836	$ 3,352	$ 2,191	$ 515	$	$

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $11,094**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,600** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **169,642**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,777** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees